The Shared Debt Recovery Scheme – submission to the Department of Health

Avant is Australia's largest medical defence organisation, providing medical indemnity insurance to medical practitioners and medical practices. We assist and advise medical practitioners in responding to Medicare compliance audits, as well as providing general medico-legal advice to medical practitioners and medical practices insured under our polices, on contractual, employment and Medicare matters.

Determining the secondary debtor

What types of employment or contractual arrangements should the Minister be aware of when determining which classes of persons (or organisations) will be included in or excluded from the Scheme?

From our experience, doctors can:

- be employees;
- be independent contractors;
- be lessees;
- have an agreement under which a medical practice provides services to the doctor but there is no other relationship between the parties; and
- have locum agreements via locum agency.

It is very rare for doctors to claim money directly from Medicare in any of these arrangements. Many contacts (whether employment contracts or contracts for service) require the doctor to provide an authority to the practice to claim money from Medicare.

Salaried doctors in private practice
Doctors are employed, paid salaries and do not gain any financial benefit from the item numbers that are billed to Medicare. Doctors in this group often relinquish control of appointment-making and billing, and do not receive benefits from Medicare. Salaried doctors include general practice registrars.

Doctors treating private patients in public hospitals
The provider numbers of doctors working in public hospitals are used to bill Medicare for private patients. The hospital generally arranges the billing and receives the benefits and often doctors are not aware when their provider number is being utilised in this system.

Independent Contractors
Doctors are not employed by the practice but are contracted to provide services to patients. The practice receives payments, takes a percentage which represents a payment for services provided by the practice to the doctor and pays the balance to the practitioner.

Since the announcement of the Shared Debt Recovery Scheme last year, Avant has reviewed employment/service contracts (as a legal service on behalf of its members) which seek to absolve the practice/secondary debtor of having to repay any debt owed to Medicare. The contracts have included extended indemnity clauses for practices if the Department finds that a debt is owed because of the doctor's billings. These clauses contract the doctors to pay the entire amount regardless of the benefit received by the practice. These clauses would seem to negate the intention and purpose of this legislation. Avant would be interested in the Department's view on these clauses and would welcome the opportunity to discuss this further with the Department.

Avant has also become aware of attempts by employers to build into employment contracts specific numbers of MBS items that the doctors must charge, for example, specifying the number of chronic disease management items per week or month.

On the other hand, in some current arrangements between hospitals and doctors, hospitals assume responsibility for any repayments to Medicare if their billing arrangements contravene the Medicare requirements.

A final consideration is that medical indemnity insurance does not cover payment of any debts to the Commonwealth where an amount is required to be paid under the Scheme.

Making a shared debt determination

Under what circumstances could control or influence by a secondary debtor lead to the making of a 'false or misleading' statement?

As noted in the previous question, it is very rare for doctors to claim money directly from Medicare. Doctors can be strongly influenced by the practices for whom they work. This is particularly the case in our experience with more vulnerable practitioners, such as General Practice Registrars and other junior doctors, and International Medical Graduates (IMGs).

Examples where control or influence by a secondary debtor could lead to the making of a false or misleading statement include:

- Practice staff attempting to influence which MBS item numbers should be charged (for example, short vs long consultation or a non-urgent vs urgent attendance item).
- Practices making errors due to a misunderstanding or lack of knowledge about the application of particular MBS item numbers.
- Practices simply making mistakes when billing Medicare for example through typographical or other errors. These could all lead to the making of a false or misleading statement.

IMGs, who rely on their working visa to reside in Australia, are particularly vulnerable and over-represented in the Medicare audits that we assist our members with. It has been our experience that IMGs are less confident about disagreeing with practice staff about the MBS item number that should be billed for particular services. This is usually in fear of losing their job, visa status and residency in Australia, which has distressing consequences for them and their families.

Junior doctors, including GP Registrars, are also particularly vulnerable to control or influence by secondary debtors. From the experiences of our membership, we believe that this is because they are less confident to contend issues regarding MBS requirements with their employers/others as they are characteristically inexperienced utilising the system and rely on the employment opportunity as the main component of their training.

What forms of evidence could the Chief Executive Medicare or their delegate consider to determine whether a secondary debtor obtained a financial benefit from the making of a 'false or misleading' statement?

Forms of evidence to be considered by the Chief Executive Medicare or their delegate include:

- The contract that employs or otherwise engages the primary debtor by the secondary debtor.
- Evidence of payments from Medicare and payments to practitioners such as documents evidencing receipt of payment from Medicare, doctor's pay slips, practice's pay records).

Practices do not always pass on the correct amount of Medicare billings to the doctor and this can be for a number of reasons. They include:

- practice is purposefully withholding payment (for example where the practice is in financial difficulty so recovers the money from Medicare but does not pay the doctor);
- practice makes a mistake;
- practice does not pay the amount the practice contracted to pay (for example, practice contracted to pay an hourly rate for the first 3 months but only pays a percentage of billing OR the written contract provides for two different percentages and the lower one is paid).

The Chief Executive Medicare or their delegate could also request practice policies, procedures or protocols relating to the billing of patients/Medicare. This will help the Chief Executive Medicare or their delegate understand what the procedure is in a specific practice and who has control or may influence the billing.

The Chief Executive Medicare should also consider the setting and practices of the secondary debtor and how these practices affect the Australian health care system. For example, private patients treated in public hospitals compared with patients at general practice medical centres.

The default proportion of a shared debt

Is a proportion of 65%/35% (primary debtor owing/secondary debtor owing) an appropriate prescribed percentage?

No

If you answered "no", what would be an appropriate prescribed percentage and why?

Avant recommends that the Chief Executive Medicare should assess each case on an individual basis rather than working from a prescribed percentage.

While we acknowledge that a 65%/35% proportion is a common split between the benefits earned between the doctor and the organisation, this is not always the case. In the context of employed practitioners, the doctor is often paid a salary that is not proportionate to the financial benefit received by the practice generated from the doctor's billings. In addition, we have assisted doctors who have received as little as 10% of the Medicare benefit for particular items (with 90% of the benefit received by the organisation).

Assessing each case on its merits, would allow flexibility in determining a fair and accurate amount on further allocation of responsibility in repaying any Medicare compliance debt.

We believe a prescribed percentage in the context of a current employment/engagement relationship (between the primary and secondary debtor) has the potential to create uncomfortable working environments and even lead to formal employment disputes.

We support practitioners and organisations working together to minimise incorrect billing and promptly repaying Medicare compliance debts.

Both the primary and the secondary debtor will have a personal financial interest in making its share of the debt as low as possible. If a percentage is prescribed with the ability to vary the percentage, it is likely that many cases will include a submission from either debtor (likely both), requesting a variation of the percentage of debt that each must pay. The dividing of the debt, as well as one debtor having to volunteer the other, has the potential to create difficulties in the ongoing working relationship between the parties. This would be contrary to one of the aims of the Scheme, which is to encourage practitioners and organisation to work together to minimise incorrect billing and promptly repay Medicare compliance debts.

Under what circumstances might the Chief Executive Medicare or their delegate decide to vary the percentage of the debt that is recoverable from the secondary debtor?

If there is a prescribed percentage, the Chief Executive Medicare or their delegate should decide to vary the percentage of the debt that is recoverable from the secondary debtor where it can be demonstrated that the primary debtor was improperly influenced or controlled into making a misleading or false statement.

The Chief Executive Medicare should also consider the actual benefit-payment-proportion between the primary and secondary debtor. This will help ensure that there is a fair apportionment of responsibility between the debtors in the case of non-compliance.

Additional questions or comments on the Scheme

Do you have any concerns or questions about the Scheme that were not addressed in this consultation?

Avant welcomes the Shared Debt Recovery Scheme as a positive initiative. Often our members lament at having to pay 100% of the Medicare benefit in circumstances where they have given up control of their Medicare billing, and the billing functions are centralised within organisations and this has contributed to incorrect billing practices.

It is important that education is provided to practitioners and non-practitioners who utilise the MBS billing system to help them better understand the item descriptors and 'hot spots', in an attempt to reduce incorrect billing practices. This should be complemented with comprehensive resources for users to utilise at all other times.

It is not clear to Avant what happens in the circumstances where a shared debt determination is made and either debtor has become insolvent or otherwise cannot or refuses to pay the debt. This should be clarified as soon as possible.

We would welcome the opportunity to collaborate with the Department on the further detail of the proposed legislative instrument.

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